Entered - 02/06/01 - sb
CL01L0087 - DIANNE C. MITCHELL

01- K -0280

CLAIM OF: **SANDRA S. SIRHAN,**
through her insurance carrier,
Healthcare Recoveries, Inc.
P. O. Box 37440
Louisville, Kentucky 40233-7440

For damages alleged to have been sustained as a result of personal injuries at the Atlanta Airport on March 7, 2000.

THIS ADVERSED REPORT IS APPROVED

BY: Rosalind Rubens Newell by Robin M. Cox DCA
ROSALIND RUBENS NEWELL
DEPUTY CITY ATTORNEY

DEPARTMENT OF LAW - CLAIM INVESTIGATION SUMMARY

Claim No. 01L0087 Date: February 8, 2001

Claimant /Victim SANDRA S. SIRHAN
BY: (Atty)(Ins. Co.) Healthcare Recoveries, Inc.
Address: P. O. Box 37440, Louisville, Kentucky 40233-7440
Subrogation: X Claim for Property damage $ _____ Bodily Injury $ 3,979.00
Date of Notice: 02/05/01 Method: Written, proper X Improper _____
Conforms to Notice: O.C.G.A. §36-33-5 X Ante Litem (6 Mo.) _____
Date of Occurrence 03/07/00 Place: Atlanta Airport
Department Aviation Division: _____
Employee involved _____ Disciplinary Action: _____

NATURE OF CLAIM: The claimant is attempting to recover for medical expenses paid on behalf of its insured due to an injury she received at the airport. However, the claim as presented does not comply with the requirements of notice as set forth in O.C.G.A. §36-33-5, the six month statute of limitations expired to receipt of the claim. Furthermore, insurance carriers are prohibited by Georgia state law from the subrogation of personal injury claims.

INVESTIGATION:

Statements: City employee _____ Claimant _____ Others _____ Written _____ Oral _____
Pictures _____ Diagrams _____ Reports: Police _____ Dept Report _____ Other _____
Traffic citations issued: City Driver _____ Claimant Driver _____
Citation disposition: City Driver _____ Claimant Driver _____

BASIS OF RECOMMENDATION:

Function: Governmental X Ministerial _____
Improper Notice _____ More than Six Months X Other X Damages reasonable _____
City not involved _____ Offer rejected _____ Compromise settlement _____
Repair/replacement by Ins. Co. _____ Repair/replacement by City Forces _____
Claimant Negligent _____ City Negligent _____ Joint _____ Claim Abandoned _____

Respectfully submitted,

INVESTIGATOR - DIANNE C. MITCHELL

RECOMMENDATION:

Pay $ _____ Adverse X Account charged: 1A01 _____ 2J01 _____ 2H01 _____
Claims Manager: _____ Concur/date 02-08-01
Committee Action: _____ Council Action _____

FORM 23-61

HEALTHCARE RECOVERIES, INC.
P.O. Box 37440
Louisville, Kentucky 40233-7440
Telephone: (800)419-6451

February 2, 2001

ENTERED - 2-6-01 - SB
01L0087 - DIANNE MITCHELL

M Dianne Mitchell
02/05/01

CITY OF ATLANTA LAW DEPARTMENT
ATTN: DIANNE MITCHELL
68 MITCHELL STREET SW #4100
14TH FLOOR
ATLANTA, GA 30335

RE: Your Insured: Hartsfield Airport
Our Insured: SANDRA S SIRHAN
Health Plan: UNITED HEALTHCARE
Loss Date: 03/07/00
Our File No.: MU-S261544334010
Your File No.:
Your Policy:

Dear Sirs:

Attached is an updated Consolidated Statement of the total benefits paid or incurred by the Health Plan to date in connection with the injury sustained by the above referenced patient.

As these charges may not be final, please contact our office before settlement so we may give you the final figures. If you require further information or clarification, please contact us.

REMITTANCE ADVICE

File Number: MU-S261544334010 Amount Enclosed: $_____

Member Name: SANDRA S SIRHAN

(Please include file number on your check and enclose this remittance advice)

Sincerely,

Michael J. Hoffmann
(800)419-6451

004571214500

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